

**SOUTH CAROLINA DEPARTMENT OF DISABILITIES AND SPECIAL NEEDS
CO CRITICAL INCIDENT VERBAL REPORT**

PERSON TAKING REPORT _____

PERSON MAKING REPORT _____

REGION _____ AGENCY _____

PHONE NUMBER OF PERSON
MAKING REPORT _____ DATE _____ TIME _____

NATURE OF INCIDENT _____

IMMEDIATE ACTION TAKEN _____

PERSON ASSIGNED TO INVESTIGATE _____

LOCATION _____ PHONE NO. _____

NOTIFICATION:	To be Notified (Check)	Initial Report	Final Report
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STATE DIRECTOR	_____	_____	_____
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DEPUTY STATE DIRECTOR	_____	_____	_____
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ASST. SPECIAL PROJECTS	_____	_____	_____
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OTHER

[Print This Form](#)

SAMPLE